

FAMILY PRESENCE AT THE BEDSIDE DURING
CARDIOPULMONARY RESUSCITATION

A RESEARCH PAPER
SUBMITTED TO THE GRADUATE SCHOOL
FOR THE DEGREE
MASTER OF SCIENCE

BY

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May 2011

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RESEARCH PAPER: Emergency Nurses Current Practices and Understanding of Family Presence during Cardiopulmonary Resuscitation.

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DATE: May, 2011

Patients' requiring Cardiopulmonary Resuscitation (CPR) impact many individuals, families and communities on a daily basis. A significant factor to family presence during resuscitation (FPDR) is a greater understanding of health care professionals on the benefits of FPDR to patients and families. The purpose of this descriptive quantitative study is to examine Emergency Nurses' current practices and understanding of FPDR in the emergency department. The target population is 60 emergency nurses with at least six months emergency nursing experience representing three Midwestern facilities in Indianapolis, Indiana. Data will be collected using a questionnaire developed by the Emergency Nurses Association which will provide information regarding nurses taking families to the bedside during resuscitation efforts or would do so if the opportunity arose. Additional information obtained will include written policies and guideline existence on the practice of FPDR to meet the needs of patients, families and staff by providing consistent, safe, and caring practices for all involved. Results will provide information on the safe implementation and practices of FPDR.

Chapter I

Introduction

Twenty four deaths occur per minute in the United States (www.medicare.gov). Death ranges from having ended existence as a living or growing thing, to being without power to move, feel or respond. Grief can be a multi-faceted response to loss, particularly to the loss of someone or something beloved. Emotional reactions of grief can include anger, guilt, anxiety, sadness and despair. Ones' coping skills involves the process used by individuals to offset or overcome the situation. A growing population of people is requesting being present at the bedside during cardiopulmonary resuscitation of family members.

Type, expectedness and process of death often impact a survivor's loss and grief experience. Larson (2005) asserts while there is no way around dying and death, there are ways to effectively cope with such an unavoidable life experience. Research supports individuals who possess a strong sense of personal competence as likely to approach difficult tasks (death) by viewing the challenges as something to master rather than avoid (Larson, 2005).

Family presence at the bedside during cardiopulmonary resuscitation is an important component of the patients' care. Many families report feeling as though their

presence at such a time is helpful to both them and the patient. A lot of facilities remain reluctant to allow family presence during resuscitation typically because of the belief that the family will somehow disrupt the providers' ability to focus solely on the resuscitation. Allowing family to be present and seeing the extraordinary effort put forth by the code team may give real meaning to the words "we did everything we could."

Background and Significance

The essence of clinical nursing practice is to provide comfort and healing by attending to patients' physical, emotional, and spiritual needs. At times, undervaluing emotional and spiritual care may occur because of time limitations or fear of vulnerability. Nurses understand that they are instruments of healing and that giving of themselves creates healing in the nurse, patient and family. As nurses, our primary question about any change must be: Will this benefit the patient above all?

The status of the profession of nursing has evolved over many decades. The profession is regulated by state laws that govern the scope of practice. Healthcare organizations further define standards of practice governed by the mission, organizational structure, and approach to patient care. Critical thinking is a hallmark skill of professional nurses who use reason not only to determine what to do, but the best way to do it based on research.

According to Atwood (2008), resuscitation involves medications, potentially bone breaking chest compressions, needle sticks for intravenous access and rapid movement of staff completing tasks. Resuscitation requires complete accuracy for medication

calculation and an adherence to an algorithm based on the patients' response to the medications. Resuscitation also requires skill to place tubes in almost every orifice of a patients' body.

What is the best course of action for the patient and family during a life or death resuscitation? Maybe, we should ask them and let them participate in the end-of-life care decisions. Family presence is easy to define; it is "the presence" of family in the patient care area. In 1995, the Emergency Nurses Association (ENA) developed clinical guidelines supporting the option of family presence during CPR and invasive procedures. Since then, the American Heart Association (AHA), American Association of Critical Care Nurses and others have also issued guidelines supporting family presence (Atwood, 2005).

Resuscitation is an intense situation; every second is critical and the surrounding scene is not pretty. Organizations fear the potentially long-term anguish families can suffer in response to watching aggressive resuscitation measures. Many questions such as: what if families interfere, what if families distract, and can staff work effectively in the midst of frightened, and grieving family remain unanswered.

Standard practice in most emergency departments precludes family presence during emergency events. One of the most undeniable arguments against family presence is the fear that families might lose emotional control and interrupt patient care. Acknowledging family presence as an option and establishing a standardized protocol would aid in the protection of safety for patients', families and staff. Health care institutions strive to hear patients and families are satisfied with the care provided.

Trying to meet all the needs of everyone involved in a resuscitation attempt would be difficult at best, we must prioritize those needs and the patients' needs come first. The patient is the priority, but in a broader view, the family is part of the patient. It is the nurses who often take the initiative in raising family presence during a code. For witnessed resuscitation to become standard, code teams and emergency personnel must work together to create clear-cut policy for their facility.

Research suggests that families want to be given the option to remain during cardiopulmonary resuscitation and those who remain generally report a favorable experience and feel it is beneficial to all involved (Atwood, 2005). Instituting and promoting family presence guidelines may provide mechanisms to ensure that the needs of patients', family members, and healthcare providers are met.

Statement of Problem

The Emergency Nurses Association (ENA) has endorsed the practice of family presence during resuscitation, yet registered nurses (RNs) and physicians continue to be concerned that family members will interfere with procedures or compromise the care being delivered to the patient (Madden and Condon, 2007). Further study of nurses' perceptions and practices regarding family presence during resuscitation is needed.

Purpose

The purpose of this descriptive quantitative study is to examine Emergency Nurses' current practices and understanding of FPDR (family presence during resuscitation) in the emergency department.

Research question

What are nurses' practices and understanding of FPDR in the emergency department?

Theoretical Framework

Dr. Jean Watson developed a theory of caring that is insightful of the nursing professions identity. This model places value on the relationship between the caregiver and the care recipient. The nurse is viewed as a co-participant in the human caring relationship and is committed to enhancing human dignity. The goal of nursing is "protection, enhancement, and preservation of human dignity and humanity" (Fawcett, 2005, pg. 554). Using the caring model as the backbone for nursing processes will provide staff a holistic approach to their patients. Watsons' theory of caring provides a theoretical, ethical, and philosophical framework for the nursing profession practice.

Definition of terms

Conceptual definition for Nurses Practices and understanding of FPDR

They are nurses' perceptions of actual family presence during resuscitation in the patient care area, in a location that affords visual or physical contact with the patient during the procedure and their practices toward family presence (Boehm, 2008).

Operational Definition for Nurses Practices and Understanding of FPDR

Nurses' practices and understanding of FPDR will be measured by a survey questionnaire (Mian, Warchal, Whitney, Fitzmaurice, & Tancredi, 2007) that consists of

three steps designed to measure factors which are thought to influence healthcare professionals' willingness to promote family presence.

Assumptions

This study will be grounded by the following assumptions:

1. The practice of family presence must be viewed within the overall family centered care within the emergency department (ED).
2. Nurses will report accurate practices and understanding of FPDR.
3. An educational effort to influence healthcare providers' perceptions about family presence is possible.

Limitations

1. Generalization of the study's findings to non emergency department nurses is one limitation of the study.
2. Although the study will identify nurses' understanding and practices of FPDR, family members' perceptions will not be investigated.

Summary

The frequency of family presence at the bedside is increasing and affecting the lives of thousands. Family presence is considered essential and knowledge is thought to improve nurses' practices. Information about family presence during resuscitation can help to tailor interventions to promote positive outcomes. Caring behaviors and emotional care can improve quality care and foster patients' feelings of safety and reduce anxiety. Supporting families in the option to be present or not during resuscitation will ensure that

the needs of patients, family members, and healthcare providers are met during a stressful event.

Chapter II

Literature Review

The Emergency Department is the most common area in the hospital for a cardiac arrest to occur (Madden and Condon, 2007). When death occurs, it is most frequently as a result of an unforeseen or unanticipated event that has a profound effect on any family. The presence of family members in the resuscitation area is a controversial issue and not universally accepted among the health care profession. As America's population ages, it is certain that large numbers of patients dying in Emergency departments will continue to increase.

Organization of Literature

The literature review consists of studies that reveal family presence should be an option offered to all patients and families utilizing the emergency department. Healthcare organizations should assist staff with minimizing obstacles to family presence and encourage supportive behaviors promoting family presence at the bedside during cardiopulmonary resuscitation. Additional descriptive studies will help to facilitate and promote family presence. Recent literature was reviewed in order to depict current practice.

Theoretical Framework

Dr. Jean Watson developed a theory of caring that is reflective of the nursing profession's identity. Originating back to Florence Nightingale, nurses are seen as caring, concerned, and empathetic. Working within an integrated academic nursing curriculum, she identified a theory that works with any population and in any setting. Watsons' theory speaks to nursing actions or processes that are beneficial to human beings. The ability to connect with a person is reflected in gestures, facial expressions, touch and other human means of communication. Caring is the basis for Watsons' theory and according to Dr. Watson a caring-healing modality may take place in any environment. Human beings and their environment are considered connected. A high value is placed on the relationship between the caregiver and the care recipient. Caring is the basis for Watsons' theory, it involves human-to-human interaction at the highest level possible. Every interaction between a patient and nurse has the opportunity to make a connection. Watson stresses the need for nurses to be aware of their own consciousness; in turn they will be influenced by the interaction (Fawcett, 2005).

Knowledge and perceptions of family presence

Beckstrand, Smith, Heaston, and Bond (2008) surveyed emergency nurses regarding perceptions of obstacles and supportive behaviors in end-of-life care. Family presence during resuscitation (FPDR) is viewed as an obstacle in many emergency departments across the United States. Studying these obstacles which stand in the way of optimal care will assist in providing continued quality care to patients and families.

The population for this study included random sampling of 700 emergency nurses from the national Emergency Nurses Association (ENA). The sample represented

approximately 2.4% of ENA membership. The members were considered eligible for the study if they had worked in an emergency department and lived in the United States, were able to read English, and had cared for at least one patient in an end of life setting. Upon returning the questionnaire it was assumed consent was granted to participate in the study (Beckstrand et al. 2008).

A 70 item questionnaire with 51 questions being a Likert-type response option was mailed to randomly selected Emergency Nurses Association members. A numerical code was assigned to each questionnaire prior to mailing to ensure confidentiality. This tool measured obstacles utilizing 0 (not an obstacle) to 5 (extremely large obstacle). A similar scale of 0 (never occurs) to 5 (always occurs) was used for scoring frequencies. The tool also included perceived supported behavior magnitude scores which were obtained by multiplying each supportive behavior item's mean size by the item's mean frequency. Results were compiled and data was entered into software to be evaluated and analyzed (Beckstrand et al. 2008).

Findings from this study revealed the obstacle with the largest magnitude score was emergency nurses having workloads too high to allow adequate time to care for dying patients and their families. Four of the highest ranked obstacles included: (a) family members not understanding what "life-saving measures" really means; (b) the nurse having to deal with distraught family members; (c) family members calling the nurse regarding patient status; and (d) the nurse having to deal with angry family members (Beckstrand et al., 2008).

The highest scoring supportive behaviors were (a) allowing family members' adequate time with the patient after death and (b) providing a peaceful and dignified

bedside scene for family members. The second highest scoring supportive behavior was good communication between the physician and RN who was providing care to the dying patient. The third highest supportive behavior was related to the importance of teamwork by having the physicians involved agree with the direction of care and letting social workers, nursing supervisor or religious leader provide care to the grieving family. Deaths occurring in the emergency department are often rapid, traumatic and unexpected. Although nurses may not have time to form bonds or prepare themselves for dying patients, they must be prepared at all times as they cannot anticipate what may happen at any moment (Beckstrand et al., 2008).

Beckstrand et al. (2008) hopes the results of this study help facilitate discussions regarding end of life care within emergency departments. Additional research would be helpful to decrease obstacles with the highest magnitude and increase high magnitude supportive behaviors as well as increasing nurse education in end of life care. If changes such as these can occur, it is anticipated that a more comfortable and improved experience for emergency staff and families will occur. Review of practices regarding end of life care and family presence during resuscitation currently happening in emergency departments will assist nursing staff to provide the best care possible.

The purpose of the qualitative descriptive design study by Madden and Condon (2007) was to examine emergency nurses' current practices and understanding of family presence during cardiopulmonary resuscitation in the emergency department. Nurses are encouraged to encompass families while providing care to patients yet many nurses feel inadequate to provide care to both the patient and the family at the same time.

Madden and Condon (2007) used a panel of experts consisting of three critical care nurses, three emergency nurses, and one physician who evaluated the relevance and clarity of the questions to enhance content reliability. The survey was piloted on 10 emergency nurses working in a different emergency department and was not included in the main study. Piloting the questionnaire resulted in changes to the questions to aid in establishing content reliability. Data was collected from a convenience sample of 100 emergency nurses with at least six months' emergency nursing experience in a level one trauma center utilizing a survey questionnaire developed and used by the Emergency Nurses Association (ENA). All of the participants were involved in working and dealing with resuscitation efforts routinely.

Confidentiality and anonymity was respected throughout the participation and writing up of this study by Madden and Condon (2007). A survey questionnaire consisting of 15 closed-ended questions was utilized for the study. Section One was comprised of demographic characteristics including age of participant, sex, nursing qualification, and years of experience, work hours and position. Section Two examined nurses' knowledge of policies and practices in relation to family presence and the number of times the nurse was involved in family presence during resuscitation. Section Three examined nurses' preferences for policy development and Section Four addressed listing of barriers and facilitators regarding family presence during resuscitation. Data was analyzed to screen, identify and code missing data. The panel of experts utilized to establish content validity rated all items and overall questions as 100% relevant in measuring family presence during resuscitation practices.

Of the 100 questionnaires distributed, a total of 90 were completed and returned. The majority of respondents was female and employed as direct care staff nurses. Greater than 50% of the responses had more than four years of nursing experience and 41.6% were associate degree nurses. 65% of nurses were correct that no policy existed in their unit for family presence with one-third not knowing if such a policy existed. Seventy-four percent of nurses would prefer a written policy allowing the option of family presence during CPR. Twenty percent of nurses preferred no written policy but would like the option of family presence. A small number (2.2%) preferred the unit to prohibit the option of family presence. Within the past year, more than half of respondents had taken family members to the bedside during CPR. Fifty-eight percent of nurses believed FPDR would cause conflicts within the emergency team. According to Madden and Condon (2007), the emergency nurses also believed conflict with the medical profession was a major concern during resuscitative efforts. More than ninety six percent of nurses felt a greater understanding by health care professionals on the benefits of family presence during resuscitation to patients and families would be useful.

This study by Madden and Condon (2007) heightened emergency nurses' knowledge and awareness of the subject of family presence during resuscitation. It also illustrated the need for ongoing education and policy development within the clinical setting. The findings further contributed to the existing body of nursing knowledge and practice of family presence during resuscitation in emergency care. Family presence during resuscitation may reduce anxiety, eliminate doubt about the procedure of resuscitation, and facilitate the grieving process. As health professionals and patient

advocates, we promote participation at the beginning and middle of life, so one should ask why we have the right to exclude them from the end.

Regardless of personal opinions, tradition is to isolate grieving families during resuscitative efforts although studies show that family presence positively affects both family and staff regardless of outcome. Promoting and instituting family presence requires vigilant nurses who advocate for each resuscitation patient and family to do what is best for the patient. The purpose of a descriptive qualitative study by Knott and Kee (2005) was to explore beliefs and experiences of RNs about family presence during cardiopulmonary resuscitation.

This study done by Knott and Kee (2005) took place in various acute settings, including the emergency department, cardiac stepdown, intensive care and labor and delivery. Knott and Kee sought RNs employed in acute care settings who were likely to be either witnesses to or participants in cardiac resuscitation where families were available. Knott and Kee additionally sought RNs who worked on different hospital units and had different work responsibilities. Demographic and background data included age, sex, nursing education and clinical experience. Ten nurses were solicited as Knott and Kee believed this number would provide sufficient sample and they would be able to obtain maximum variation in perspectives on the family presence phenomenon.

Knott and Kee (2005) asked each participant to sign an informed consent including agreement to have interview replies tape recorded for all 16 questions. Each interview was approximately 45 minutes in length and conducted at a mutually agreed upon location. Interview questions were open-ended, focused on target phenomenon, intended for hospital staff, and allowed for an interview format. Each participant

confirmed involvement in CPR and proceeded to their beliefs about family presence. Additionally the participants were asked about factors which might influence the option of FPDR being offered, examples of events where family members were present and to assess FPDR impact on their performance and comfort level. Knott and Kee utilized the constant comparative method of data analysis for responses to the interview questions. Two co-investigators independently read and analyzed the data to identify major themes and then met to discuss their individual analysis. The findings were combined and condensed into mutually agreed-upon results thus providing evidence for dependability and credibility.

Four themes emerged from this study by Knott and Kee (2005). The first theme to emerge involved conditions under which FPDR is or is not a viable option such as a family member being hysterical, is the event following a long term illness or a sudden event. The second theme revolved around the family's medical knowledge and the implications of their background. Intubations and IV's are not always done in one attempt and may seem hazardous when viewed by family members. The third theme involved consideration of the patient's age when determining suitability of FPDR. Parents may want to be with their children during this process, but may not understand the pathophysiology involved in medical therapy. Lastly, the nurses commented if the family's choice is to be at the bedside, then a staff person should be assigned to the family who can explain every detail.

Findings in this study also showed nurses remain committed to providing individualized patient care as FPDR remains at the forefront in healthcare. In this study by Knott and Kee (2005), one can conclude FPDR has not achieved widespread

acceptance regardless of endorsement by professional associations. Although focus is on the patient in crisis situations, families and loved ones may be affected the rest of their lives by decisions made to include or exclude them during moments of crisis. Suggestions for additional research should include why barriers for FPDR continue to exist as well as reevaluating the presence of loved ones at the bedside during resuscitation. Personal opinions and experiences should not override what may be in the best interest of the family experiencing a crisis situation.

FPDR is a controversial subject which can lead to strong discussion and disagreement among health care professionals. In a study done by Holzhauser and Finucane (2008), staff and relatives' attitudes regarding FPDR were examined. The aim of this study was to implement and evaluate the practice of FPDR. This three year research project focused on surveying all staff immediately following resuscitation of a patient.

The setting for this study by Holzhauser and Finucane (2008) was the emergency department of a major tertiary referral teaching hospital. Participants for the study included any staff member present during resuscitation of a patient. The population included all patients presenting with or without altered level of consciousness, hypotension, respiratory distress or the need for cardiopulmonary resuscitation.

A questionnaire was used to determine staff perceptions of resuscitation immediately after the event with relatives present or not being present. All questions were dichotomous, multiple dichotomous, open-ended or a likert scale. The questions were developed based on a review of literature and advice from expert clinical staff. There were a total of 106 surveys out of 167 returned resulting in a return rate of 63%.

Demographics included years of emergency experience, age in years, and position within the department (Holzhauser and Finucane (2008).

Holzhauser and Finucane (2008) found this research provided a good overview and structured analysis of staff attitudes to family presence immediately following resuscitation. The occupation of respondents varied and included nursing and medical staff of varying positions, social workers, clergy, and medical and nursing students. No difference was noted between the medical and nursing staff. Staff responses provided a variety of advantages and disadvantages that arose during the resuscitation process. Actual advantages included being able to gain a patient history quickly and family members were comforted by being present and able to see everything that was being done for the patient. Disadvantages included the positioning of relatives during resuscitation and the length of time it sometimes took to explain what was occurring.

Additional results of this study by Holzhauser and Finucane (2008) revealed staff attitudes toward relatives' presence during resuscitation were positive. Staff identified that being able to get a faster history enabled them to make timely clinical decisions resulting in positive care. Maintaining open communication enabled clarification of processes and provided opportunities for staff to discuss their concerns.

Holzhauser and Finucane (2008) concluded further study should focus on psychological and physical effects of family presence on staff and presence of relatives on patient outcomes. The effects of resuscitative measures can be more than a humbling experience and provide understanding that emergency care is more than just the patient's illness.

For decades, it seemed as if nurses feared that when family members were present during a code they would either get in the way or become so distraught that there would be more patients' to provide care for. The focus of a study by Holzhauser, Finucane and De Vries (2006) was to determine the effects on relatives of family presence in the emergency department during resuscitation.

The setting for this study by Holzhauser et al. (2006) was the emergency department of a large tertiary teaching hospital in Queensland, Australia. Participants were relatives and met the following criteria: over the age of 18, immediate family or significant other, provided written consent and must not be disruptive to the treatment. The final sample consisted of 100 patients with 40 patients in a control group and 60 patients in an experimental group. Demographic data collected included age, previous experiences and gender of participants (Holzhauser et al., 2006).

A survey questionnaire was developed with a variation in questions to provide continuity between the control and experimental group of subjects. To reflect the outcome of the patient, questions were worded to suit the relative of the patient who lived or was deceased. To ensure reliability of the tool, it was piloted on the first 10 relatives participating in the project. The questions included asking relatives if they were invited to be present during resuscitation, did they feel pressured to be present, was communication adequate before, during and after the resuscitation, was staff supportive and finally, an open ended question relating to any other comments (Holzhauser et al., 2006).

Findings from this study done by Holzhauser et al. (2006) revealed the majority of the relatives were the spouse or partner of the patient and over the age of 50. Replies from the open-ended questions were also described. The common responses involved:

(a) I was worried about being in the way; (b) it's a personal choice; (c) I was very scared and emotional; and (d) I preferred to be present. Respondents also revealed their memories of the resuscitation were focused on the activity, how fast it was, how much was being done for the patient and how reassured and cared for the family felt.

Findings in this study highlight the important need for a support person in the over-all care of the patients and their relatives in the emergency department. The research additionally high-lighted the importance of giving caregivers enough confidence to include relatives during care of the patient as well as making them part of the team. Holzhauser et al. (2006) concluded additional research needs to be developed within this area that relates to psychological effects of relatives presence during resuscitation and follow-up support.

Participants in the study valued the opportunity to be present during resuscitation and no adverse events were reported. Overall, it would seem as if relatives would be more able to cope with the final outcome of their relative by being present during resuscitation. As nurses, supporting and advocating for family presence during resuscitation must continue to be supported with evidenced based practice.

Professional organizations such as the American Heart Association advocate for family presence during resuscitation. In a study done by McClenathan, Torrington and Uyehara (2002), healthcare professionals were surveyed for their opinions regarding family presence during resuscitation.

McClenathan et al. (2002) developed a survey to evaluate health care professionals' opinions about family presence as well as reasons why healthcare professionals would oppose family member presence during resuscitation. The survey

consisted of 6 open ended questions covering cardiopulmonary experience, opinions on family member presence, and demographic data. All attendees walking through the door of a 4 day meeting of the American College of Chest Physicians in San Francisco, California were offered the opportunity to complete the anonymous survey. The survey was deliberately kept short to allow completion within approximately 2 minutes and the consent to participate in the study was implied upon completion of the survey. This survey was not a rigorously controlled study; therefore prospective research study may have affected its reliability and validity.

A total of 592 surveys were completed with 28 indicating they had never been present during an attempted resuscitation, thus they were excluded. There was a significant difference among professionals based on regional location. Professionals practicing in the northeastern states were less likely to allow family presence during resuscitation while Midwestern professionals were more likely to allow family presence when compared with the rest of the United States. Healthcare professionals disapproving of family presence did so because of fear of psychological trauma to family members, performance anxiety of the healthcare team, medico legal concerns and fear of distraction for all involved with providing care (McClenathan et al. 2002).

This study done by McClenathan et al. (2002) indicates that the majority of all health-care professionals surveyed do not support family presence at the bedside during resuscitation (FPDR). It is speculated the difference between physicians and other healthcare professionals' support of FPDR may be due to the fact that physicians have ultimate responsibility for the outcomes of the resuscitation efforts. McClenathan et al.

2002 recommend additional rigorous scientific studies of FPDR are completed before widespread implementation.

The movement to allow family presence has steadily evolved because of the support of professional organizations, attention of the media and continued research on this controversial topic. In a study done by MacLean et al. (2003), their objective was to identify policies, preferences and practices of critical care and emergency nurses regarding family presence during resuscitation (FPDR).

A survey design was used by MacLean et al. (2003) to determine the family presence practices of critical care and emergency nurses. The survey was mailed to a random sample of 1500 emergency and critical care nurses who were members of their respective professional organizations. No identifying information was included on the surveys and informed consent was implied by the participant's response to the questions and return of survey.

A 30 item survey was developed which included questions about demographic characteristics of respondents; preferences and hospital policies related to family presence; respondents' practices; and the option to share any comments about the respondents' personal or professional experiences with family presence. A national panel of experts consisting of 3 critical care nurses, 3 emergency nurses, and 1 physician rated the relevance and clarity of the survey to establish content validity (MacLean et al., 2003).

Findings revealed only 5% of the respondents worked on units that had written policies allowing the option of family presence. Similarly, 51% of nurses worked on units that had no formal written policy, but allowed family presence. A total of 37% of nurses

preferred a written policy permitting family presence. A total of 36% of nurses had taken family members to the patient's bedside and 21% said although they had not taken family members to the bedside they would do so in the future if the opportunity arose (MacLean et al., 2003).

MacLean et al. (2003) reveal since nurses often facilitate the families' presence at the bedside, critical care and emergency departments both need to decide where they stand on the issue. As a result of influence exerted by both consumers and professional organizations, critical care and emergency departments will also need to determine whether formal or informal guidelines are needed to support family presence. Nearly all of the respondents worked on units that had no written policy on family presence, yet three quarters of the respondents preferred family presence be allowed. MacLean et al. believe their results suggest practitioners and researchers need to identify the most effective interventions and explore the difference in preparing and supporting patients' family members at the bedside during resuscitation.

Research is needed to explore how often families are brought to the bedside and the support of a delivery of care which promotes a family-centered care environment. The reasons a nurse may not take the family to the bedside may include personal preference, comfort level in dealing with patients' families, lack of formal guidelines and peer pressure in an environment that does not support family presence. An attitude of dissension among staff members is likely when the practice and support of family presence is supported and implemented by a minority of the healthcare workers.

Healthcare professionals have mixed opinions about family presence, but nurses tend to take the lead in advocating for patients and families. A study by Mian, Warchal,

Whitney, Fitzmaurice, and Tancredi, (2007) focused on the impact of nurses' and physicians' attitudes and behaviors toward family presence during resuscitation.

The setting was an 898 bed urban academic medical center level 1 emergency department that receives more than 77,000 visits per year. The sample included all nurses and physicians working in the department who agreed to complete the surveys at two points; at the start of initiating a family presence program and 1 year after implementation. The initial survey was completed by 86 nurses and 35 physicians, and the follow up survey was completed by 89 nurses and 14 physicians. Mian et al. (2007) included demographic data related to age, sex, educational level and experience in the emergency department.

The anonymous survey consisted of 3 parts designed to measure the major factors thought to influence the staffs' willingness to adopt family presence. A 30 item Likert scale was used to measure attitudes, values and behaviors. Each question had 5 potential responses, with 1 being "strongly agree" and 5 being "strongly disagree." Twelve questions addressed personal and professional experience with family presence. Content validity was enhanced through expert review. Twelve former emergency department nurses pretested the initial survey and after minor revisions, internal reliability was acceptable for the total items as well as for the subscales (Mian et al., 2007).

Findings from Mian et al. (2007) revealed nurses showed stronger support for the rights of patients to have their families present than did physicians. Additional findings revealed physicians' support family presence in some circumstances, but feel ambivalence about family members seeing how they manage patients. Findings in this study also showed participants believe family presence is a nurse-driven practice. As

nurses continue to advocate for patients' families, physicians will have the opportunity to experience the value and benefit to families.

In many organizations during resuscitative efforts, patients' family members are often barred from the patients' rooms and may never have the opportunity to see their loved ones alive again. In a study done by Wagner (2004), the focus was on the experiences, thoughts and perceptions of family members during cardiopulmonary resuscitation in the intensive care unit.

The study was completed in a 700 bed urban community hospital coronary care unit. Participants were adult family members over the age of 18 who had family members which received cardiopulmonary resuscitation. These family members were near the patients when cardiac arrest occurred and were asked to participate in the study within 24 hours of the resuscitation (Wagoner, 2004).

Each interview was conducted in a private place agreed upon by the participant and investigator. Participants were asked to describe the events which occurred during the resuscitation by answering open-ended questions such as where the family member was when the event happened, was the person allowed in the room and, if not in the room, where did they wait, what feelings and emotions were experienced, who was available to support the family member during the resuscitation, and did a healthcare professional provide updates during the resuscitation. The interview process was approved by hospital administration and the nursing department (Wagoner, 2004).

Although family members expect the team to do its job in resuscitating patients, they also feel the need to be close to and protect the patient. Findings from this study revealed family members feel they lose autonomy and do not gain any ground when they

attempt to negotiate their way into the resuscitation area. Additionally family members cannot determine what is going on when they are not provided information during the resuscitation process. Families who are in crisis require and need reassurance and information to cope effectively when a loved one is critically ill. Wagner (2004) concluded that family members place an enormous amount of trust in the healthcare team and by addressing family needs a unique aspect of care unfolds: a caring presence and support.

According to Wagner (2004), many healthcare professionals are inclined to think that patients' family members cannot handle the seriousness of resuscitation or the performance involving invasive procedures. Also, resuscitation efforts could be hindered by a family member who becomes disruptive or loses control thereby forcing the healthcare team to focus on them rather than the patient. Evidence continues to indicate family presence is beneficial to patients' and their families.

In a study by Duran, Oman, Jordan, Koziel, and Szymanski (2007), the objective was to describe and compare beliefs and attitudes toward family presence during resuscitation. The surveys used in this study were written in an interview format with items scored on a 4 point Likert scale. Possible responses were strongly disagree (1), disagree (2), agree (3), and strongly agree (4). Content validity was established through expert review by school of nursing faculty, a nurse research scientist, pastoral care, and physicians and nurses from the emergency department.

A total of 202 healthcare providers responded to a study collected at a 300 bed academic hospital during a 3 month period. A total of 72 family members and 62 patients responded to the surveys. Family members and patients were excluded from the study if

less than 18 years of age, non-English speaking, confused, delirious, emotionally distraught, and/or incapable of decision making as assessed by a bedside nurse. The family members and patients were approached individually by a surveyor which accounted for the high response rate. The healthcare providers were surveyed via interoffice mail or placed in unit specific mailboxes for nurses. The surveys included preaddressed envelopes for completed surveys to be returned to the principal investigators (Duran et al., 2007).

The mean scores from the scale items were summed and converted to an overall mean family presence attitude score (M-FPAS); the greater the M-FPAS, the more positive the attitude toward family presence. Demographic data collected included age, race, and years in practice for the healthcare professionals group and sex, race, marital status and Education for the patients' and family members group (Duran et al., 2007).

Findings from this study by Duran et al. (2007) revealed the majority of healthcare providers supported family presence during resuscitation. Common identified themes emerging from the healthcare data collected included worries about family members fainting, getting in the way and causing disruptions which could lead to poor outcomes if attention was diverted away from care of the patient to the family member. In addition, healthcare providers expressed feelings of performance anxiety such as discomfort with being watched and feeling stressed if they were not successful with resuscitation which could result in lack of communication among team members when family members were present. Overall, healthcare providers commented that family presence should be an option, not a protocol, and that all factors should be taken into consideration when deciding whether family presence should be an option.

Additional findings from this study by Duran et al. (2007) revealed family members felt it was their right to witness a loved one's resuscitation and would like the option to participate. In seeing what was being done for their loved ones, family members also felt they would be able to better understand the patients' condition. Family members further believed that they could control their emotions and actions and would be able to tolerate the scene of resuscitative measures.

Duran et al. (2007) recommend that family presence be studied in nonacademic hospitals and medical surgical units to allow for more generalizability of findings. The authors concluded that family presence is becoming a more acceptable practice and may benefit both patients and patients' families. It would be beneficial if future research could focus on a shorter survey which includes scale items to potentially increase the response rate of healthcare providers. Additionally, research regarding current family presence protocols and their effects on healthcare providers, patients and families should be evaluated. Family presence can be effectively and safely implemented with a multidisciplinary approach and recognition of each care situation no matter how big or small the facility.

The debate exists between the "big city" hospital and the "small county" hospital about practices involving family presence at the bedside. In a study by Macy, Lampe, O'Neil, Swor, Zalenski, and Compton (2006), the focus involved comparing support for, and perceptions of family presence in urban and suburban emergency departments.

The study took place among emergency department personnel employed by four large Midwestern hospitals (two urban and two suburban). The focus of the study was to compare the perceptions, experiences, and attitudes toward family witnessed

resuscitations between the urban and suburban hospital personnel. Macy et al. (2006), asked the Emergency department personnel were asked to respond to 24 statements including demographic information (i.e. age, sex, race, religion, and occupation), past participation in resuscitation attempts with family presence, preferences and feasibility of family presence and their overall perception of the psychological consequences. The participants were asked to report if they agreed, disagreed, or were not sure with statements regarding family presence, while five of the statements were dichotomous in nature (yes/no).

There were 236 staff surveyed, of whom 218 responded (108 urban, 110 suburban). The majority of the respondents were female, white, and Christian. Approximately half of the participants had participated in a resuscitative effort while a member of the family was present. Overall, half of all ED personnel felt it was appropriate for an escorted family member to be present during resuscitative efforts of the patient. Respondents of each location indicated they would like training on how to incorporate a family member into the emergency department during a resuscitation event. The patient population of these facilities is predominantly black or white, respectively; there was no evidence that personnel/patient cross-racial discordance affected support of family presence (Macy et al., 2006).

Findings from this study by (Macy et al., 2006) revealed previous experience with family presence was strongly associated with favorable perceptions of the practice. The authors concluded that urban hospitals have smaller staff/patient ratio than suburban hospitals and this may be an area for additional study. Findings also revealed that both settings reported a good process for providing emotional support to bereaved family

members. Additionally, only 25% of personnel were familiar with literature about family presence or had read an article on family presence. This study concluded that hospital setting and prior experience with family presence appears to influence the support strongly and that most participants in both settings were open to training and research regarding this topic.

Family presence is an important component of the patients' care and many families report feeling their presence at such a time is helpful to both them and the patient. Developing the knowledge of healthcare personnel who are often referred to as "gatekeepers to the bedside" during resuscitation is vital (Atwood, 2008). Few acute care facilities have policies about family presence and healthcare professionals and often make case-by-case decisions about whether family members are given the option to be present.

Healthcare professionals report 3 primary reasons for their reluctance to invite patients' families to be present: the unpleasantness of what families will see, fear that the resuscitation team will not function well with patients' families in the room, and anxiety that family members will become disruptive. The objectives of this study by Twibell et al. (2008) involved testing 2 instruments to measure nurses' perceptions of family presence during resuscitation, explore demographic variables and perceptions of nurses' self confidence, the risks and benefits related to such family presence in a broad sample of nurses from multiple hospital units, and to examine differences in perceptions of nurses who have and who have not invited family presence.

Participants for the study were registered nurses (RNs) and licensed practical nurses (LPNs) employed at a regional medical center in Muncie, Indiana. To be included

in the study, participants had to be 18 years or older, be able to read English, and hold a nursing license in Indiana (Twibell et al., 2008). Some units of the hospital routinely used family presence, others did not and the hospital did not have a policy about family presence. Participation in the study was voluntary and anonymous and all data was confidential. A total of 375 nurses participated in the study for a response rate of 64%.

One of the instruments used in the study by Twibell et al. (2008), was the Family Presence Risk-Benefit Scale (FPR-BS) to measure nurses perceptions of the risks and benefits of family presence to the family, patient, and resuscitation team. The other instrument was the Family Presence Self-confidence Scale (FS-CS) to measure nurses' self-confidence related to managing resuscitation with patients' families present. The instruments both had 5-point Likert response options, from strongly disagree (1) to strongly agree (5). Years of experience as a nurse, current professional certifications, role as a RN or LPN, educational level, ethnicity, sex and age were demographic variables which were measured. Response options for how many times an invitation was given to a family member to be present during resuscitation were never, fewer than 5 times, and 5 times or more.

Findings from this study by Twibell et al. (2008) revealed dramatically divergent responses of participants, from strongly agree to strongly disagree reflecting the continuing controversial nature of family presence during resuscitation. The study revealed nurses most likely to invite family presence were RNs who were certified, were members of a professional organization, and were working in the emergency department. Additional findings suggested that once nurses participated in family presence, they perceived more benefits than risks in the practice and had more self confidence.

The authors concluded that nurses hold widely divergent perceptions of risks, benefits, and their own self-confidence related to family presence. Increased participation in professional nursing organizations may provide greater exposure to current research and evidence-based practices related to family presence (Twibell et al. 2008).

Summary

Family presence at the bedside is a major issue facing a lot of healthcare staff today. The literature review provided evidence that both patients and healthcare workers have input about this practice. The findings support Dr. Jean Watsons' theory of human caring. Watsons' theory speaks to nursing actions or processes that are beneficial to human beings. Watson identifies the nursing process as human-to-human caring. Nursing at its highest level provides physical, procedural, and an emotional connection. The physical body is treated along with mind and spirit. The nurse is viewed as a co-participant in the human caring relationship. In the emergency department setting, this would start with the relationship established with the primary nurse. The caring factors are woven throughout each step of the visit. Enabling and sustaining hope is paramount when working with the critically ill patient. Providing a supportive environment to patients and families while they are making a life and death choice is a crucial element and carative factor (Fawcett, 2005).

Chapter III

Methods and Procedures

Family presence at the bedside during resuscitation is an important aspect of the patients' care. Nursing staff have an on-going influential impact on patients' care from the time of arrival until disposition. Literature reviews report families feel their presence at such a time is helpful to both them and the patient. This study is a partial replication of Mian et al. (2007) study. The purpose of this study is to examine attitudes and behaviors of nurses toward family presence during cardiopulmonary resuscitation.

Research Question

What are nurses' practices and understanding of FPDR in the emergency department?

Population, Sample and Setting

After approval is received from the institutional review board of the hospital, the study will be conducted in an 898 bed urban academic medical center in the Midwest. The emergency department is a level 1 adult and pediatric trauma center with 50 beds and a patient census of 77,000 per year. The sample will include all nurses currently working in the emergency department. Agreement to participate in the study will be implied with returned completed surveys.

Protection of Human Subjects

This study will be submitted to the institutional review board for approval prior to conduction. Ethical consideration will be given attention for this study by adhering to ethical principles for research studies. Prior to the initiation of this study, a consideration of the potential to improve patient care versus risks to family members was thoughtfully assessed. A fair selection of subjects will occur with risks and benefits impartially distributed. The benefits from this study include awareness of health professionals about family presence at the bedside leading to implementation of evidenced based practice. Voluntary participation along with the right of participants to refuse any part of the study will be explained comprehensively. All data collected will be anonymous.

Procedures

A packet containing the surveys will be given to each staff nurse by the study author. A cover letter will explain the purpose and risks of the study. Staff members who are interested in participating will return the attached survey indicating their consent. A secure drop-off box will be located in the staff lounge. To maintain awareness of the practice, posters will be placed throughout the department designed as newspaper headlines and include research information about family presence. A video highlighting a family describing their personal experience as well as differing opinions from healthcare providers will assist in stimulating dialogue. Guidelines will be developed to help staff members determine which families may benefit most from family presence. Role-playing and scripting will be included to guide staff in offering families the option of family presence and in helping to structure their visit.

Instrumentation, reliability, and validity

Data will be collected by survey questionnaire (Mian, 2007). The questionnaire consists of three steps. Step 1 will be an anonymous survey consisting of 3 parts designed to measure major factors which are thought to influence professionals' willingness to promote family presence. A Likert scale with 30 items to measure professional attitudes, values and behaviors with 5 potential responses from 1 being strongly agree and 5 being strongly disagree. Step 2 will be twelve questions addressing the respondents' personal and professional experience with family presence. Additional questions regarding professional practice and educational sessions will be included. Step 3 will be questions eliciting demographic information about the respondent, such as age, sex, educational level, years of practice, and experience in the emergency department. Content validity will be enhanced through expert review. Twelve former emergency department nurses will pretest the initial questionnaire with the potential for minor revisions to occur.

Data Analysis

Descriptive statistics will be used to analyze study variables and to determine which nurses offer family presence at the bedside as an option. Mean scores will be calculated for each variable. Items will be ranked in order from most frequently performed to least frequently performed options. The relationship between family presence at the bedside as an option and nurses attitudes toward family presence will be addressed with correlational analysis. The most commonly used correlation measure, Pearsons' correlation, will be used to determine the degree of linear relationship between variables. Significance level will be set at 0.05, meaning that there is a probability of 5% or less of having a Type I error.

Research design

This study will use a descriptive correlational design. The purpose of descriptive research is to describe concepts and identify relationships among variables (Burns & Groves, 2005). A non-experimental design is appropriate because the intent of this study is to describe relationships among clearly defined, identified variables. This study will examine family presence at the bedside and describe relationships between family presence at the bedside and practice. No attempt to control or manipulate the study situation will occur; nor will a casual connection be explored.

Summary

In this chapter, the methods and procedures to be used for this study are described. The specific variables examined will be family presence as an option and nurses' attitudes towards family presence during cardiopulmonary resuscitation. A descriptive correlational study design will be used to examine the relationships that exist in situations involving family presence. Data will be collected via culturally sensitive and easy to read surveys distributed to healthcare employees. Data will be analyzed with descriptive statistics and correlational analysis at the 0.05 significance level. This study will be a partial replication of a previous study by Mian et al. (2007) and attempt to validate previous findings while providing valuable information which may lead to interventions that may promote family presence at the bedside as a common practice.

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